STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PODIATRISTS' SERVICES

NMAP pays for covered podiatry services at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount;
   d. For clinical laboratory services including collection of laboratory specimens by venipuncture or catheterization, the amount allowed for each procedure code in the national fee schedule for clinical laboratory services as established by Medicare; or
   e. The reasonable charge for the procedure as determined by the Medical Services Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medical Services Division determines that the current allowable amount is -
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

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Providers will be notified of changes and their effective dates.

NMAP pays for injections at the wholesale cost of the drug plus an administration fee determined by the Department.

Site of Service Limitation: Payment for surgical procedures that are primarily performed in office settings is reduced by 12% when performed in hospital outpatient settings (including emergency departments). NMAP accepts Medicare's determination of surgical procedures that are primarily performed in office settings.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

OPTOMETRISTS' SERVICES

NMAP pays for covered optometrists' services at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule) - the provider's actual cost (including discounts) from the provider's supplier. The maximum invoice cost payable is limited to reasonable available cost;
   c. The maximum allowable dollar amount; or
   d. For clinical laboratory services including collection of laboratory specimens by venipuncture or catheterization, the amount allowed for each procedure code in the national fee schedule for clinical laboratory services as established by Medicare; or
   e. The reasonable charge for the procedure as determined by the Medical Services Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medical Services Division determines that the current allowable amount is -
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

NMAP pays for injections at the wholesale cost of the drug plus an administration fee determined by the Department.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

CHIROPRACTORS' SERVICES

NMAP pays for covered chiropractors' services at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medical Services Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medical Services Division determines that the current allowable amount is -
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

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State ____Nebraska____

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

CERTIFIED REGISTERED NURSE ANESTHETISTS

The Nebraska Medical Assistance Program calculates payment for CRNA/AA services as follows: The total of the units assigned to the CPT/ASA procedure plus the appropriate number of time units are multiplied by the appropriate conversion factor for medically directed or non-medically directed services. This amount must not exceed the amount allowable for physicians' services for the procedure. Theses services are paid according to the Nebraska Medicaid Practitioner Fee Schedule.

When anesthesia services are provided by an anesthesiologist and a CRNA/AA at the same time, NMAP will make payment only for those services provided by the anesthesiologist.

NMAP does not make additional reimbursement for emergency and risk factors.

NMAP does not make payment for CRNA/AA services for secondary procedures. When multiple surgical procedures are performed at the same time, NMAP pays for only the major procedure.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

HOME HEALTH SERVICES

The Nebraska Medical Assistance Program pays for medically prescribed and Department-approved home health agency services provided by Medicare-certified home health agencies. The Department may request a cost report from any participating agency.

For dates of service on or after July 1, 1990, NMAP pays for home health agency services at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for each respective procedure in the Nebraska Medicaid Home Health Agency Fee Schedule in effect for that date of service.

The Nebraska Home Health Agency Fee Schedule is effective for July 1 through June 30 of each fiscal year.

The Department reserves the right to adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
3. Adjust the allowable amount when the Medical Services Division determines that the current allowable amount is -
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Home Health Agency Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

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State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES FOR SUITABLE USE IN THE HOME

NMAP pays for covered durable medical equipment, medical supplies, orthotics and prosthetics, at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medical Services Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medical Services Division determines that the current allowable amount is -
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

ATTACHMENT 4.19-B
Item 8

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PRIVATE DUTY NURSING SERVICES

Payment for approved nursing services will be the lower of -

1. The submitted charge; or
2. The maximum allowable fee as established by the Department.

TN# MS-86-13

Supercedes

TN# MS-83-21

Approved Nov 14, 86

Effective 5/01/86

*Substitute per letter dated 1/12/98 *

ATTACHMENT 4.19-B
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

CLINIC SERVICES

NMAP pays for clinic services and outpatient mental health and substance abuse services at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medical Services Division (indicated as "BR" - by report - or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1, through June 30 of each year.

Revisions of the Fee Schedule. The Department reserves the right to adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medical Services Division determines that the current allowable amount is -
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule; during the year that it is effective. Providers will be notified of the revisions and their effective dates.

Transmittal # MS-95-13
Supersedes
Transmittal # MS-89-7

Approved FEB 09 1998 Effective 7/25/95

"Substitute per letter dated 1/12/98"

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

NMAP pays for injections at the wholesale cost of the drug plus an administration fee determined by the Department. Only the administration fee is paid when a physician uses vaccine obtained at no cost from the Nebraska Department of Health.

Payment for Psychiatric Day Treatment Services: Payment rates for psychiatric day treatment services for individuals age 21 and older will be set on a per day basis. Rates are set annually, for the period July 1, through June 30 . Rates are set prospectively for this period, and are not adjusted during the rate period. Providers are required to report their costs on an annual basis. Providers desiring to enter the program who have not previously reported their costs, or that are newly operated, are to submit a budgeted cost report, estimating their anticipated annual costs.

Providers shall submit cost and statistical data on the required form, based on the timeframes in 471 NAC 20-003.08. Providers shall compile data based on generally accepted accounting principles and the accrual method of accounting based on the provider's fiscal year. Financial and statistical records for the period covered by the cost report must be accurate and sufficiently detailed to substantiate the data reported. If the provider fails to file a cost report as due, the Department will suspend payment. At the time the suspension is imposed, the Department will inform the provider via letter that no further payment will be made until a proper cost report is filed. In setting payment rates, the Department will consider those costs which are reasonable and necessary for the active treatment of the clients being served. Such costs will include those necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care requirements, and discharge planning. The Department does not guarantee that all costs will be reimbursed. The cost reporting document is used by the Department only as a guide in the rate setting process. Actual costs incurred by the providers may not be entirely reimbursed.

Psychiatric day treatment centers operated by the State of Nebraska will be reimbursed for all reasonable and necessary costs of operation, excluding education services. State-operated centers will receive an interim payment rate, with an adjustment to actual costs following the cost reporting period.
